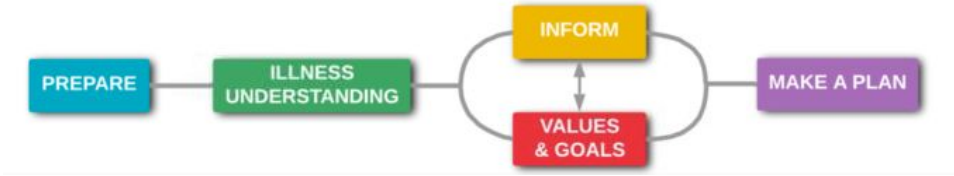
Guide for Clinicians
COVID-19 Goals of Care Discussion

Target Population: No underlying serious comorbidities and COVID-19;



Goal: To have an initial goals of care conversion, identify a substitute decision maker, and explore values and wishes in case the patient's condition deteriorates in the hospital

Example situation: 65 yr old person, living independently; has mild hypertension and hypercholesterolemia

Step 1: Introduce yourself and the discussion

"Mr. … my name is…. I know you are being admitted as you have coronavirus and need care in the hospital. Is that right?

Step 2: Explore illness understanding

"Can I ask you...what do you know about coronavirus specifically?

Step 3: **Provide information** about their underlying illness and the effect of coronavirus

Speak slowly, pausing often. Use simple language and wait for response and reaction; If you are not sure if they understand, ask them to repeat it back to you.

"There has been a lot of information in the news about coronavirus. What we do know is that most people have mild to moderate illness and then recover…and that is what I am expecting for you...but some people have severe illness, and can get very unwell...
"At this time, I am hopeful that you will recover.
"But… It is possible you will get sicker -- too sick to talk with me…so, I'd like to spend some time making sure I know enough about you to take the best care of you I can.

Pause and let information get absorbed: If they have an emotional reaction, pause and respond supportively to the emotion.

 Acknowledgement: Ariadne Labs' Serious Illness Conversation Guide and VitalTalk were used in developing both the structure and content of this document.

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Step 4: Document the Substitute Decision-Maker

"so, the first thing we can talk about is: if you were to get sicker and couldn't talk for yourself, do you know who is the person you'd want to speak for you?

"in the law in Ontario, everyone has an automatic "back-up person" called a Substitute decision-maker…let's talk about who your automatic SDM is

Using the hierarchy at the end of the document, help determine the automatic SDM, or, if patient has assigned a POA, get that information and document it.

Step 5: Learn more about your patient's values - not specific treatments

Next, I'm going to ask you some questions that help us and your SDM in case they need to make decisions for you…we aren't going to make decisions right now, I'm just exploring your thoughts …

1. *Think about the care you might need if you have a critical illness. What worries or fears come to mind? Do you know anyone who has had to think about this before?*
2. *Tell me about the state you would consider unacceptable to keep living in.*
3. *"What concerns or worries do you have about what lies ahead for you?"*
4. *What would be important for people to know about you so we can take the best care of you if you became critically ill?*
5. *Is there anything else we should know about you to help us care for you best?*

Step 6: Summarize a possible plan for critical illness, based on what they've said:

From what I've heard, it sounds like if you were critically ill, we should:

e.g. use all intensive measures such as chest compressions and a ventilator, but if it wasn't working and we knew you weren't going to recover, then we should stop and ensure you are comfortable e…is that right? … you wouldn't want us to prolong your suffering at the end of life…nor have you on life support for an extended period of time…is that right?

e.g. use all intensive measures such as chest compressions and a ventilator – to give you the best chance to survive…is that right?

e.g. focus our care on keeping you comfortable and allowing you to pass away peacefully – is that right? if you become critically ill, we won't prolong things at the end of life with artificial life support…we won't do chest compressions and use a shock on your heart…is that right?
e.g. continue our current plan…it is difficult to think about this…thank you for telling me everything you have…let's continue to talk about this tomorrow…does that sound okay?

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Step 7: Thank you

Thank you for having this conversation with me…I've learned a lot about you. We now know who your SDM is and that is very helpful.

I am hopeful that you will recover and go back home in the next days.

But, if not, I really appreciate learning more about you…and your values and goals…
If things do take a turn for the worse, then we will make sure we talk about this more..

Do you have any questions for me at this time?

Important information about the conversation guide

- These are suggested conversation guides only. They offer you language to use, but you will need to adapt to the specific situation you are facing.
    - For example, if the emotion is not shock, but is sadness, name that emotion: "you are right to feel so sad...you obviously care so much about your (relative)…" "you are right to be frustrated and upset...it is difficult news that I am telling you..."
- Communicate with key health care team members who can help support these conversations and the patients
- Make sure you are talking to the correct SDM when the patient is incapable
- Document your conversations
- Know what's available at your own site or region
    - Visitor Policy
    - Resource allocation policies
    - Palliative care supports from regional palliative care team
    - Availability of social work and chaplaincy support
- Know what resources your institution has to provide patient/families about COVID-19 and any triage information

Thank you to Fraser Health, BC for general tips about communication

Within your own scope of practice, provide information directly and honestly to the best of your knowledge

- Allow silence as time permits
- Acknowledge and explore emotion as it occurs. Do not just talk about facts and procedures
- Make a recommendation. In these distressing times, patients & families need to hear your professional opinion.

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- Listen more than you talk.
- Avoid premature reassurance, instead align with the patients in hoping things may improve
- Focus on patient-centred goals and priorities not medical procedures
- Do not offer a menu of interventions, especially those that are not clinically beneficial
- Use the wish, worry, wonder framework…
    - I wish allows for aligning with the patient's hopes
    - I worry allows for being truthful while sensitive
    - I wonder is a subtle way to make a recommendation

If you have any feedback about these guides, please email rachel.dragas@HPCO.ca

Additional Resources

Hospice Palliative Care Ontario	hpco.ca
Speak Up Ontario	speakupontario.ca
Ontario Palliative Care Network	ontariopalliativecarenetwork.ca
VitalTalk	vitaltalk.org

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